Gender-Specific Behavioral Health and Community Release Patterns Among New Jersey Prison Inmates: Implications for Treatment and Community Reentry

| Cynthia L. Blitz, PhD, Nancy Wolff, PhD, Ko-Yu Pan, PhD, and Wendy Pogorzelski, PhD

Mental illness and addiction disorders are more common in prison than among the general population.[1–3] In particular, rates of schizophrenia and bipolar disorder in prisons are estimated to be 1 to 5 times greater than in the population as a whole.[4] Comorbid substance abuse disorders with severe mental illness are substantially greater among inmates than among the general population and are associated with an array of adverse outcomes including increased vulnerability to relapse and rehospitalization, greater depression, and noncompliance with treatment and medications.[5]

Patterns of behavioral health disorders differ by gender within and across the general and prison populations. Men and women in the general population, although having roughly equal rates (20%) of active disorder, have dissimilar clusters of behavioral health disorders.[6] Men, for example, have higher active rates of antisocial personality disorder and alcohol and drug abuse than women. By contrast, women are more likely to have active disorders of somatization, depression, generalized anxiety, panic, and phobia.[6]

Although relatively little is known about mental health problems within prison populations, what is known deviates from patterns found between genders in the general population. In general, rates of mental illness are higher among female inmates than among men in state and federal prisons and local jails.[2] According to national data collected by the Bureau of Justice Statistics, 20% of women confined in state prisons are diagnosed with a mental disorder, compared with 16% of men.[2] Moreover, the prevalence of substance abuse and dependence are higher in the prison population, for both men and women, than in the general population.[6,7]

These data, although limited in their details and methodological rigor, have been used to demonstrate the need for behavioral health

Objectives. We describe behavioral health diagnoses and community release patterns among adult male and female inmates in New Jersey prisons and assess their implications for correctional health care and community reentry.

Methods. We used clinical and classification data on a census of "special needs" inmates (those with behavioral health disorders) in New Jersey (n = 3189) and a census of all special needs inmates released to New Jersey communities over a 12-month period (n = 974).

Results. Virtually all adult inmates with special needs had at least 1 Axis I mental disorder, and 68% of these had at least 1 additional Axis I mental disorder, a personality disorder, or addiction problem (67% of all male and 75% of all female special needs inmates). Of those special needs inmates released, 25% returned to the most disadvantaged counties in New Jersey (27% of all male and 18% of all female special needs inmates).

Conclusions. Two types of clustering were found: gender-specific clustering of disorders among inmates and spatial clustering of ex-offenders in impoverished communities. These findings suggest a need for gendered treatment strategies within correctional settings and need for successful reentry strategies. (*Am J Public Health.* 2005;95:1741–1746. doi:10.2105/AJPH.2004.059733)

interventions for inmates during their incarceration and to facilitate their reintegration into the community after release.[2,8] It is indisputable that inmates have substantial behavioral health needs, which if left untreated or only marginally treated will influence their behavior in the institution and later in the community after release. Yet these statistics lack the specificity necessary to guide the development of treatment for people with behavioral health and criminal justice problems in correctional settings. To the extent that inmates have clusters of co-occurring problems that differ by gender, therapeutic interventions will have to be similarly differentiated to be effective.

We explored gender patterns of behavioral health disorders among a cohort of inmates in the New Jersey prison system. Emphasis was on gender-specific patterns of Axis I mental disorders, personality disorder, and addiction disorders, which suggest particular treatment needs when these individuals are in prison and related needs and identifiable risks when

they return to the community. Of particular concern was whether inmates, either male or female, with known behavioral health disorders are returning to disadvantaged communities after completing their sentences and whether they are being released without supervision. Socially disorganized communities may be least suited to respond to the complex needs of these individuals, making it even more important for them to have formal assistance. Findings from this study provide some of the details that are necessary for designing and situating effective therapeutic and reentry interventions for men and women during and after their incarceration.

METHODS

Definitions

Inmates with behavioral health disorders in the New Jersey prison system are classified as "special needs." These are individuals who need or receive mental health treatment of some type while in prison.[9] Prison mental

health staff determines whether an individual has symptoms requiring mental health treatment. An inmate may be placed or removed from the special needs roster at any time during the incarceration period. The vast majority of special needs inmates have an Axis I mental disorder; a small minority (1% of men and 0.6% of women) have only an Axis II disorder.

Data Sources and Variables

We used 2 data sets compiled by the New Jersey Department of Corrections. The first data set includes demographic, incarceration history, and psychiatric diagnosis data for a census of adult special needs inmates located in the 9 New Jersey prisons for men and the 1 New Jersey prison for women on August 10, 2002 (data not available to public). Of the approximately 16 700 male inmates in these facilities, 2715 inmates (or 16.0%) were classified as special needs inmates (with 2687 having an Axis I mental disorder). The percentage of special needs men in New Jersey prisons is consistent with national estimates.

Of the 1267 female inmates in New Jersey, 474 (37%) were classified as having special needs (with 471 having an Axis I mental disorder), compared with 25% nationwide.[6] This discrepancy in rates for women may be accounted for by the comprehensive screening and treatment of inmates in New Jersey prisons resulting from a monitored court settlement (from a class action lawsuit) regarding the delivery of mental health services to inmates.[10,11] Typical procedures for screening female inmates for mental disorders are not sufficiently sensitive to the fact that a significant proportion of women in prison have experienced some form of childhood abuse (physical, mental, and sexual)[12] and that childhood abuse is often associated with anxiety disorders and mood disorders in adulthood.[13] Comprehensive screening includes such childhood abuse–related disorders. In addition, because women tend to avail themselves of mental health treatment when it is available, as it is in New Jersey prisons, this higher-than-average rate of mental disorder within the New Jersey female prison population may provide a more accurate picture of disorder within the female prison population nationwide than do estimates drawn from national

data based on less-comprehensive screening of inmates for mental disorders.

The second data set that was compiled by the New Jersey Department of Corrections and used in this study includes demographic and offense data on all released adult special needs inmates from New Jersey prisons over a 12-month period, August 1, 2003, through July 31, 2004 (n=974).

Sample Characteristics

Table 1 compares the characteristics of special needs inmates from the 2 data sets by gender. Percentages in this table were calculated from the total number of cases in each column. In general, the adult special needs inmate population in New Jersey consisted primarily of men, individuals in their mid-30s, and members of minority groups: about half of special needs inmates were Black.

In comparison with male inmates, a greater percentage of female inmates were incarcerated for drug-related offenses, but a lower percentage were incarcerated for violent types of offenses (i.e., those involving the use of force or the threat of using force). In all, about half of male special needs inmates had a violent crime as their most serious type of conviction.

The composition of the special needs inmate population was quite similar to the special needs released inmate population in terms of race/ethnicity and age. One noteworthy difference exists: women with special needs were overrepresented among the released inmate population (21%) compared with their representation within the universe of special needs inmates (15%). This difference can be explained by the fact that special-needs women are less likely to be incarcerated for violent crimes (which carry longer sentences) (Table 1).

Analytic Strategy

The complexity of behavioral health disorders within the population of special needs inmates in New Jersey (n=3189) was determined by examining the comorbidity patterns among those with specific types of mental and substance abuse diagnoses. A matrix grouping approach was used to explore the patterns of Axis I and II diagnoses assigned among male and female inmates.

The matrix grouping was undertaken in 2 steps. The first step classified the Axis I mental disorders into 5 types: psychotic disorders or dementia (type 1); bipolar (type 2); all other mood disorders (type 3); posttraumatic stress disorder (type 4); and anxiety disorders (type 5). A sixth classification was made for those with no Axis I mental disorder. Unique cases with and without multiple diagnoses

TABLE 1—Characteristics of Special Needs Inmates in New Jersey Prisons (2002) and Special Needs Inmates Released From New Jersey Prisons (2003–2004), by Gender

Selected Characteristics	Special Needs Inmates, 2002 (n = 3189)		Special Needs Released Inmates, 2003–2004 (n = 975)	
	Men (n = 2715)	Women (n = 474)	Men (n = 772)	Women (n = 203)
Demographics				
Race/ethnicity, %				
White	42	38	42	39
Black	48	59**	47	58*
Hispanic	10	3**	12	3**
Mean age, y (SD)	36 (10.4)	35 (7.9)**	37 (9.7)	37 (8.0)
Type of offense				
Violent, %	54[a]	36[a]**	27[b]	15[b]**
Drug-related, %[c]	18	31**	32	40*

Note: The statistical significance of between-group differences was tested with independent-samples *t*-test for means, and χ^2 test for percentages.
[a]Ever convicted of violent crime.
[b]Most serious offense was a violent crime.
[c]Controlled dangerous substance was most serious offense.
*$P<.05$; **$P<.001$.

TABLE 2—Behavioral Health Problems Among Male Special Needs Inmates Within the New Jersey Prison Population, 2002 (n = 2715)

Cluster of Axis I Mental Disorders	Cluster of Axis I Mental Disorders				Personality Disorder (Axis II), %	Active Addiction Diagnosis, %
	Type 2, %[b]	Type 3, %[c]	Type 4, %[d]	Type 5, %[e]		
Type 1 (n = 752)[a]	9.8	20.3	5.2	8.4	27.8	39.8
Type 2 (n = 571)[b]	...	31.5	5.8	20.8	36.3	55.7
Type 3 (n = 907)[c]	...	...	7.8	24.5	25.2	43.9
Type 4 (n = 77)[d]	...	...	...	35.1	36.4	37.7
Type 5 (n = 380)[e]	...	...	...	...	19.0	35.5
No Axis I (n = 28)	...	...	...	...	10.0	29.0

Note. Percentages were calculated from the total number of cases in each row.
[a] Type 1 includes schizophrenia, psychotic disorder, delusional disorder, and dementia.
[b] Type 2 includes bipolar disorder.
[c] Type 3 includes major depression, major mood disorder, depression, and dysthymia.
[d] Type 4 includes posttraumatic stress disorder.
[e] Type 5 includes obsessive compulsive disorder, anxiety disorder, panic disorder, phobia, and adjustment disorders.

TABLE 3—Behavioral Health Problems Among Female Special Needs Inmates Within the New Jersey Prison Population: 2002 (n = 474)

Cluster of Axis I Mental Disorders	Cluster of Axis I Mental Disorders				Personality Disorder (Axis II), %	Active Addiction Diagnosis, %
	Type 2, %[b]	Type 3, %[c]	Type 4, %[d]	Type 5, %[e]		
Type 1 (n = 57)[a]	10.5	26.3	12.3	8.7	14.0	73.6
Type 2 (n = 85)[a]	...	34.1	12.9	17.6	14.1	75.3
Type 3 (n = 234)[c]	...	...	11.9	21.4	12.4	62.4
Type 4 (n = 17)[d]	...	...	...	47.1	0	52.9
Type 5 (n = 78)[e]	...	...	...	...	8.9	51.2
No Axis I (n = 3)	...	...	...	...	10.0	33.3

Note. Percentages were calculated from the total number of cases in each row.
[a] Type 1 includes schizophrenia, psychotic disorder, delusional disorder, and dementia.
[b] Type 2 includes bipolar disorder.
[c] Type 3 includes major depression, major mood disorder, depression, and dysthymia.
[d] Type 4 includes posttraumatic stress disorder.
[e] Type 5 includes obsessive compulsive disorder, anxiety disorder, panic disorder, phobia, and adjustment disorders.

were assigned to the disorder type with the lowest number (ranging from 1 to 5). For example, cases with schizophrenia and depression were assigned to type 1. Cases with a nonbipolar mood disorder and an anxiety disorder were assigned to type 3. All cases in the data set were exclusively assigned to 1 of the 5 Axis I types (or the no Axis I group), which are represented by rows in the matrix (Tables 2 and 3).

The second step of constructing the matrix involved the calculation of the percentages of special needs inmates in each of the exclusive Axis I–type categories (1 through 5)

who had (1) an additional type of Axis I mental disorder, (2) a co-occurring personality disorder (Axis II), and (3) a co-occurring addiction disorder. These percentages are calculated out of the total number of cases in each row in Tables 2 and 3 and arrayed across each of the relevant columns in these tables.

The second objective of this study was to estimate the percentage of male and female special needs ex-offenders who entered disadvantaged communities on release. For the purposes of conducting this analysis, 2 of the 21 counties in New Jersey, Camden and

Essex, were designated as the most disadvantaged communities.

According to a recent Urban Institute Justice Policy Research Report,[14] 31% of adult inmates released from New Jersey prisons in 2002 returned to Essex and Camden Counties (16% to Essex and 15% to Camden). These individuals were found to concentrate in a small number of communities within these counties, with 13% of all released inmates returning to Newark (Essex County) and an additional 10% returning to the city of Camden (Camden County). Essex and Camden counties, and especially the cities of Newark and Camden, are significantly more disadvantaged than other parts of the state. The 2003–2004 release data (n=974) were used to examine the extent to which male and female special needs ex-offenders differentially relocated to either of these counties.

RESULTS

Behavioral Health Needs

Eighteen percent of the adult prison population was identified as special needs. Rates differed by gender. Women were more likely than men to be classified as special needs (37% vs 16%, respectively, $\chi^2=11.3$; $P<.001$).

Within the special needs inmate population (n=3189), men were more likely to have a diagnosis of psychotic disorders (28% for men, compared with 12% for women; $\chi^2=47.002$; $P<.001$), whereas women were more likely to have depressive disorders (58% for women, compared with 45% for men; $\chi^2=24.615$; $P<.001$). The results for men and women appear in Tables 2 and 3, respectively. The percentages reported in both tables were calculated from the total number of cases reported for each row (i.e., from the total number of special needs inmates with a particular Axis I diagnosis).

Special Needs Male Inmates (n = 2715)

In addition to an Axis I diagnosis, 67% of special needs male inmates had an additional Axis I, personality (Axis II), or addiction disorder diagnosis. Specifically, 26% of men had more than 1 Axis I diagnosis, 25% had at least 1 Axis I diagnosis and a personality

disorder (Axis II), and 40% had at least 1 Axis I disorder and an active addiction disorder.

The findings shown in Table 2 demonstrate that approximately 30% of special needs male inmates had a diagnosis of schizophrenia, psychotic disorder, delusional disorder, or dementia, which is labeled type 1. The most common comorbid Axis I disorder for this special needs type was some form of mood disorder, type 3 (20.3%), but not bipolar (type 2). Roughly one quarter of type 1 male inmates had some form of personality disorder (Axis II), most commonly cluster B (i.e., antisocial personality disorder, borderline personality disorder, or narcissistic personality disorder). An addiction disorder was diagnosed in approximately 40% of male inmates with type 1 disorder.

The findings in Table 2 also show that of those male inmates diagnosed with bipolar disorder (type 2), slightly more than one third were also diagnosed with a personality disorder, and nearly 56% had an addiction disorder. For those individuals diagnosed with major depression or a mood disorder (type 3), about one quarter were also diagnosed with an anxiety or adjustment disorder (type 5). About 3 percent of special needs male inmates were diagnosed with posttraumatic stress disorder (type 4) as their most serious diagnosis.

Special Needs Female Inmates (n = 474)

Seventy-five percent of female special needs inmates had either an additional Axis I diagnosis, a personality disorder, or an active addiction disorder along with the most severe Axis I diagnosis. In particular, 23% had more than 1 Axis I diagnosis, 11% had at least 1 Axis I diagnosis and a personality disorder (most commonly cluster B), and 57% had at least 1 Axis I disorder and an active addiction disorder. Mood-related disorders were most common among female inmates.

Table 3 shows that approximately 67% of special needs female inmates had a diagnosis of bipolar disorder or depression (n=234). Moreover, roughly 30% of women with type 1 (psychotic) or type 2 (bipolar) disorders also had a depression diagnosis (type 3). The most common comorbid Axis I disorder

TABLE 4—Characteristics of Inmates Entering Essex and Camden Counties Compared With Inmates Entering Other Counties in New Jersey Prisons, by Gender: 2003–2004

	Essex and Camden (n = 241), %		All Other Counties (n = 733), %	
	Men (n = 205)	Women (n = 36)	Men (n = 566)	Women (n = 167)
Race/ethnicity				
White	26	36	47	40
Black	64	64	41	57**
Hispanic	10	0ᵃ	12	3**
Mean age (SD)	35 (9.4)	36 (7.8)	37 (9.8)	37 (8.0)
Violent crime offense	28	19	27	14**
Drug-related offense	38	31	29	43**
Served full sentence	59	47	42	47

Note: The statistical significance of between-group differences was tested with independent-samples *t*-test for means, and χ^2 test for percentages.
ᵃTwo-sided exact test was used.
**$P < .001$.

for female inmates with depression (type 3) were panic and adjustment disorders (type 5). Fewer than 1 in 7 female inmates had a diagnosis of personality disorder. However, an active addiction diagnosis was present in half to three quarters of women in the various Axis I types.

Communities Where Ex-Offenders Return

Of all special-needs inmates released in New Jersey in 2003 (n=974), about 25% (n=241) relocated to either Camden or Essex counties after release. This percentage is comparable to rates found by Travis et al.[14] in 2003 for the general ex-offender population.[14]

Table 4 compares inmates entering these 2 counties with those entering all other counties in New Jersey on a number of selected characteristics by gender. A greater percentage of men (27%) than women (18%) were released to these counties ($\chi^2=6.8$; $P<.05$), as was the percentage of inmates aged 30 years and younger (30%) compared with older inmates (23%; $\chi^2=5$, $P<.05$).

In comparison with Whites and Hispanics, a greater percentage of released special needs Black inmates entered the 2 disadvantaged counties (17%, 23%, and 32%, respectively); this difference was statistically significant ($\chi^2=30$; $P<.001$). However, there were no statistically significant differ-

ences between inmates entering Camden and Essex counties and those entering other counties on types of offense (violent vs nonviolent, drug-related vs non–drug-related). Gender differences of ex-offenders released to Essex and Camden counties were not statistically significant, and this may be partially because of the relatively small sample of women released there.

No information is available about the communities in which these inmates resided before imprisonment. Research shows, however, that 95% of people admitted to prison return to their communities of origin on discharge.[14] Roughly 60% of men and 50% of women released to Camden and Essex counties had completed their sentences and were released there without parole supervision.

DISCUSSION

Our findings suggest that virtually all adult inmates with special needs in New Jersey prisons (99%) had at least 1 Axis I mental disorder, and 68% of these had at least 1 additional Axis I mental disorder, a personality disorder, or addiction problem (67% of all male and 75% of all female special needs inmates).

There is, however, a gender-specific clustering of disorders among inmates: schizophrenia or some form of psychotic disorder and personality disorder were more likely

within the male population, whereas depressive disorders and addiction problems were more likely in the female population. In addition, there is some evidence of spatial clustering. Specifically, of those special needs inmates released over a 12-month period, 25% (27% of all male and 18% of all female special needs inmates) returned to the most disadvantaged counties in New Jersey.

Before discussing the implications of this study, we note several limitations. The data examined here, and therefore, any conclusions drawn from the findings, apply to the adult inmate and ex-offender population in New Jersey. However, New Jersey's incarceration and reentry trends are similar to those observed at the national level,[14] as are their rates of mental illness in the male prison population.[2] The higher rate of mental disorder among female inmates in New Jersey suggests the possibility of greater variation in disorders among the female inmates, which itself may be sensitive to the screening for and delivery of mental health services within correctional settings.

Reentry communities are represented by counties, which vary spatially in their economic and crime conditions. Although it is possible for ex-offenders released from New Jersey prisons to locate to the relatively well-off areas of generally impoverished counties (Essex and Camden), such a pattern is not consistent with extant evidence.[14]

National data suggests that in general, ex-offenders are more likely to return to impoverished areas with high levels of social disorganization.[15–19] Specifically, Lynch and Sabol[20] found in 2001 that 66% of state prisoners released in 1996 went into a core county, defined by a central city of a metropolitan area, and these individuals further concentrated in relatively few neighborhoods within the central cities of the core counties.[8] In 1998, Rose and Clear[21] found similar patterns for offenders released from Florida prisons, as did Travis et al.[22] in 2001 for the counties of Essex and Camden.

Our findings reveal only part of the story but are consistent with the broader literature on the spatial concentration of offenders in socially disadvantaged communities.

Another limitation concerns the determination of special needs. The data are limited in terms of measuring behavioral health disorder among inmates. In particular, special needs status may not accurately measure the types and levels of behavioral health disorders within the prison population in New Jersey.

A disorder, as measured by special needs status, requires that inmates report problems and that correctional health care staff diagnose a disorder. Because reporting and diagnosing are a function of the social and fiscal realities within prison, mental illness and addiction disorders are likely to depend on the special needs criteria and the availability of treatment. Our findings, therefore, only characterize those who have been positively diagnosed by correctional health care staff and who are actively in treatment for these problems.

Our findings suggest 2 types of clustering; gender-specific clustering of disorders among inmates and spatial clustering of ex-offenders in impoverished communities. Evidence is strongest for the first type of clustering and suggestive of the latter. Both have implications for correctional care and community reentry planning.

People incarcerated in prison have a constitutional right to treatment.[10,11] At the very minimum, behavioral health treatment in correctional facilities must be responsive to the unique presentation of disorders among male and female inmates. Approximately 95% of state correctional facilities report providing some form of mental health treatment to prisoners.[8] Substance abuse treatment, however, has not received equal attention. Roughly 1 in 4 state prisoners received any treatment for substance abuse, with a higher percentage (40%) receiving treatment if they reported drug use at the time of their offense.[23]

The most common treatment received was self-help group/peer counseling. The style of treatment inside prisons, with separate and underdeveloped substance abuse treatment, is not consistent with the clustering of disorders within the male and female inmate population.

Within a correctional environment, delivering evidence-based, integrated treatment that is gendered is challenging for several reasons. First, evidence-based behavioral health treatment strategies have been proved effective in general populations. These strategies may not achieve equal effectiveness for a correctional population in part because the setting is different (less focused on empowerment) and in part because of the presence of personality disorders. For this reason, more research is needed on treatment strategies for male and female populations with psychiatric disorder, antisocial tendencies, and addiction disorders who are confined in authoritarian environments.

Second, before disorder clusters can be concurrently treated, they must be identified. This requires systematic and comprehensive assessment. Few correctional environments have the fiscal capacity to treat the levels of psychiatric disorder likely to be found within the correctional population.[23] Given the limited budget for mental health treatment, correctional staff has little incentive to identify and treat psychiatric disorders among inmates unless inmates create institutional problems (i.e., custody or security issues) or there is evidence of "deliberate indifference"[24,25] (i.e., when the inmate can prove that prison authorities deliberately disregarded his or her need for treatment).

Problems that might underpin depression or addiction behavior, such as past physical or sexual trauma, will go undiagnosed and untreated, even though they confound treatment for other diagnosed problems. This is also true for interactions between addiction and serious mental illness, such as schizophrenia, bipolar disorder, and major depression, which have unique but interdependent recovery trajectories.

Investments in mental health during the incarceration experience are likely to be lost if not continued in the community after individuals are released. Proactive reentry planning, analogous to hospital discharge planning, is needed for individuals with behavioral health problems leaving prison. For reentry planning to be effective, it must recognize the effect of community and the interactions between individual and community resources on therapeutic recovery and prosocial community integration.

Most individuals are released from prison with minimal reentry planning.[26] Courts, as a result of class action suits or court settlements, are increasingly ordering correctional authorities to provide reentry planning for inmates with special needs.[27,28] Because

treatment for mental illness and substance abuse conditions is critical for both successful reintegration and as a guard against recidivism,[29–35] placing ex-offenders with behavioral health needs in communities without adequate services or in ways that disrupt the process of treatment places the individual and the community at risk.

Services must therefore follow the ex-offender into the community. One way to ensure this is to provide inmates with the ability to buy services. If ex-offenders are returned to the community with "buying power" to meet their therapeutic, housing, and rehabilitation needs, they will not only stimulate the local economy of their host communities but also increase their personal chances of successfully reentering the community, not prison. ∎

About the Authors

At the time of the study, Cynthia L. Blitz, Nancy Wolff, Ko-Yu Pan, and Wendy Pogorzelski were with the Center for Mental Health Services & Criminal Justice Research at Rutgers University, New Brunswick, NJ.

Requests for reprints should be sent to Cynthia Blitz, Center for Mental Health Services & Criminal Justice Research, Rutgers University, 30 College Ave, New Brunswick, NJ 08901 (e-mail: cblitz@ifh.rutgers.edu).

This article was accepted March 3, 2005.

Contributors
C.L. Blitz designed the study, led the writing, and synthesized the analyses. N. Wolff originated the study and assisted with the writing and conceptualization. K. Pan completed much of the analyses. W. Pogorzelski assisted with the study and interpretation of data.

Human Participant Protection
All data were provided deidentified, and their use was approved by the institutional review board at Rutgers University.

References

1. Davis L, Pacchiana S. Health profile of the state prison population and returning offenders public health challenges. *J Correctional Health Care.* 2003;10: 303–331.

2. Ditton PM. *Mental Health and Treatment of Inmates and Probationers.* Washington DC: US Dept of Justice, Bureau of Justice Statistics; 1999. US Dept of Justice Special Report NCJ-174463.

3. Hammett TM, Roberts C, Kennedy S. Health-related issues in prisoner reentry. *Crime Delinquency.* 2001;47:390–409.

4. Teplin LA. The prevalence of severe mental disorders among male urban jail detainees: comparison with the epidemiologic catchment area program. *Am J Public Health.* 1990;80:663–669.

5. Mueser KT, Drake RE, Miles KM. *The Course and Treatment of Substance Use Disorder in Persons With Severe Mental Illness.* Washington, DC: National Institute on Drug Abuse Research; 1997. Monograph Series, No. 172.

6. Robins LN, Regier DA. *Psychiatric Disorders in America: The Epidemiologic Catchment Area Study.* New York, NY: Free Press; 1991.

7. Peters RH, Greenbaum PE, Edens JF, Carter CR, Ortiz MM. Prevalence of DSM-IV substance abuse and dependence disorders among prison inmates. *Am J Drug Alcohol Abuse.* 1998;24:573–587.

8. Beck AJ, Maruschak LM. *Mental Health Treatment in State Prisons, 2000.* Washington, DC: United States Dept of Justice, Bureau of Justice Statistics; 2001. NCJ-188215.

9. Cevasco R, Moratti D. New Jersey's mental health program. In: American Correctional Association, ed. *The State of Corrections, Proceedings, American Correctional Association Annual Conferences, 2000.* Lanham, Md: American Correctional Association; 2001: 159–168.

10. *Estelle v Gamble,* 429 US 97 (1976).

11. *Ruiz v Estelle,* 503 F Supp 1265 (SD Tex 1980).

12. Belknap J. *The Invisible Woman: Gender, Crime and Justice.* Cincinnati, Ohio: Wadsworth; 1996.

13. Miller BA, Downs WR, Testa M. Interrelationships between victimization experiences and women's alcohol use. *J Stud Alcohol.* 2003;11(suppl):109–117.

14. Travis J, Keegan S, Cadora E. *A Portrait of Prisoner Reentry in New Jersey.* Washington, DC: The Urban Institute; 2003.

15. Burt MR, Aron LY, Lee E, Valente J. *Helping America's Homeless: Emergency Shelter or Affordable Housing?* Washington, DC: The Urban Institute Press; 2001.

16. Travis J, Petersillia J. Reentry reconsidered: A new look at an old question. *Crime Delinquency.* 2001;47: 291–313.

17. Dennis DL, Buckner JC, Lipton IS. A decade of research and services for homeless mentally ill: where do we stand? *Am Psychol.* 1991;46:1129–1138.

18. Durham M. The impact of deinstitutionalization on the current treatment of the mentally ill. *Int J Law Psychiatry.* 1989;12:117–131.

19. Federal Task Force on Homelessness and Severe Mental Illness. *Outcasts on Main Street: A Report of the Federal Task Force on Homelessness and Severe Mental Illness.* Delmar, NY: National Resource Center on Homelessness and Mental Illness; 1992.

20. Lynch JP, Sabol WJ. *Prisoner Reentry in Perspective, Crime Policy Report.* Vol 3. Washington, DC: Urban Institute Justice Policy Center; 2001.

21. Rose DR, Clear TR. Incarceration, social capital, and crime: implications for social disorganization theory. *Criminology.* 1998;36:441–479.

22. Travis J, Solomon A, Waul M. *From Prison to Home: The Dimensions and Consequences of Prisoner Reentry.* Washington, DC: The Urban Institute; 2001.

23. Mumola CJ. *Substance Abuse and Treatment, State and Federal Prisoners, 1997.* Washington, DC: US Dept of Justice, Bureau of Justice Statistics; 1999.

24. Peters RH, Matthews CO. Substance abuse treatment programs in prisons and jails. In: Fagan TJ, Ax RK, eds. *Correctional Mental Health Handbook.* Thousand Oaks, Calif: Sage Publications; 2003.

25. Wettstein RM. *Treatment of Offenders With Mental Disorders.* New York, NY: Guilford Press; 1998.

26. Metzner JL. Class action litigation in correctional psychiatry. *J Am Acad Psychiatry Law.* 2002;30:19–29.

27. Austin J. Prisoner reentry: current trends, practices, and issues. *Crime Delinquency.* 2001;47: 314–334.

28. *Brad H v City of New York,* 188 Misc 2d 470; 729 NYS 2d 348 (2001).

29. *C.F. v Terhune,* 67 F Supp 2d US 401 (1999).

30. Spaniol L, Wewiorski NJ, Gagne C, Anthony WA. The process of recovery from schizophrenia. *Int Rev Psychiatry.* 2002;14:327–336.

31. Draine J, Solomon P. Jail recidivism and the intensity of case management services among homeless persons with mental illness leaving jail. *J Psychiatry Law.* 1994;22:245–261.

32. Human Rights Watch. *Ill-Equipped: US Prisons and Offenders With Mental Illness.* New York, NY: Human Rights Watch; 2003.

33. New Jersey Reentry Roundtable. *Coming Home for Good: Meeting the Challenge of Prisoner Reentry in New Jersey.* Newark, NJ: New Jersey Public Policy Research Institute; 2003. Final report of the New Jersey Reentry Roundtable.

34. *Blueprint for Change: Ending Chronic Homelessness for Persons With Serious Mental Illnesses and Co-Occurring Substance Use Disorders.* Rockville, Md: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration; 2003. DHHS Publication SMA-04–3870.

35. President's New Freedom Commission on Mental Health. *Achieving the Promise: Transforming Mental Health Care in America.* Rockville, Md: US Dept of Health and Human Services; 2003. Final report. DHHS publication SMA-03-3832.